DOCUMENT RESUME

ED 040 418 CG 005 406

AUTHOR Russell, Kenneth R.; And Others
TITLE Innovations in Providing Community Oriented Institutional Care of Emotionally Disturbed Children.
INSTITUTION American Orthopsychiatric Association, New York, N.Y.; Colorado State Hospital, Pueblo.; Hamilton Health Association (Ontario).; Institute of Living, Hartford, Conn.
PUB DATE 26 Mar 70
NOTE 19p.

EDRS PRICE EDRS Price MF-$0.25 HC-$1.05
DESCRIPTORS *Child Care Workers, College Students, *Community Programs, Community Schools, *Demonstration Programs, *Family Programs, Psychiatric Services, *School Role, Staff Role, Students

ABSTRACT

After five years of experience the Colorado State Hospital's Community Services Team has developed a dynamic treatment model utilizing college students as child care workers, and using community schools and resources in order to maintain an optimistic viewpoint for the patient and to avoid institutionalization. Treatment is offered to the patient's entire family. The program has been extended to one isolated six-county community, and other community programs are currently being planned. Suggestions are made for modifying this approach to other areas. (Author)

ED 040418

INNOVATIONS IN PROVIDING COMMUNITY ORIENTED INSTITUTIONAL CARE OF EMOTIONALLY DISTURBED CHILDREN.

Authors: Kenneth R. Russell, MSW;[+] Charles R. Shearn, Ph.D.;[‡] Yvonne Johnson, M.D.[§]

Colorado State Hospital's Community Services Program was begun six years ago with two bold mandates. The first was to demonstrate an improved method of providing a residential treatment program for emotionally disturbed pre-adolescent children. Secondly, the program was designed to correct the weaknesses of the usual State Hospital residential treatment program for children in relationship to the concept of "institutionalization." Using these mandates both as challenge and as license to experiment, a number of unique approaches have been developed both in the area of treatment programming and in community psychiatry efforts. Program developments include the use of college students as child care workers; aggressive methods of involving parents and siblings in therapy; continuation of normal community contacts for all patients; and a de-emphasis of the concept of illness through a counter-emphasis on normal expectations for each patient. Community psychiatry efforts include shared partnerships with communities, community colleges, and community public school systems; and the establishment of small satellite residential treatment centers in those communities.

First known as the Child Research Unit, the program was developed at the

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[+]Clinical Team Leader, Community Services Team, Children's Treatment Center, Colorado State Hospital, Pueblo, Colorado.

[‡]Director of Clinical Psychology, Institute of Living, Hartford, Connecticut.

[§]Child Psychiatrist, The Hamilton Health Association, Hamilton, Ontario, Canada.

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Colorado State Hospital in Pueblo as the first children's specialty program at that Hospital. The program began on July 1, 1964, under a three year Hospital Improvement Grant from the United States Department of Health, Education, and Welfare.* Prior to the development of this program, children were housed on adult wards, with some special treatment programming in a Day Care Center. Shortly after the development of the Child Research Unit, the hospital completed plans for a larger children's residential program known as the Children's Treatment Center. Thus, for several years, Colorado State Hospital had two different children's residential treatment programs. When the Hospital Improvement Grant for the Child Research Unit expired, this program was continued with State Hospital funds. Later, for purposes of administrative simplification, the two children's programs were merged, and the Child Research Unit became known as the Community Services Team within the larger Children's Treatment Center.

Philosophy and Objectives

Both the method of treatment developed in the Child Research Unit, and the later community psychiatry efforts, can be best understood in relationship to the concept of "institutionalization." Institutionalization[1] refers to a process resulting from overprotection, depersonalization, and excessive length of hospitalization. The results for the patient are atrophy of self-confidence, erosion of social skills, deterioration of spontaneity, and blunting of adaptive skills. Other terms applied to this process are "chronic mental hospital dependency,"[2] "hospital overprotection,"[3] and "hospital habituation."[4]

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*This program was supported in part by Hospital Improvement Grant No. 1R11MH01724 from the United States Department of Health, Education, and Welfare.

Children accepted for residential treatment must be between six and thirteen years of age, must need and be able to utilize intensive treatment, and must need temporary separation from their families during the main part of their treatment need. In the interest of the child's general adjustment and emotional health over the longer term which extends beyond his period of hospitalization, care must be exercised to avoid or combat the crippling and insidious process of institutionalization. This is a shared responsibility, with the team, the family, and the community each having a role.

The process of institutionalization for a child undergoing inpatient treatment is not necessarily the same as for an adult. A child is ordinarily more dependent and more malleable than an adult, and therefore more vulnerable to the destructive effects of institutionalization. Hospitalization for a child means the disruption of his usual dependency relationships with his family, his school, and other significant persons and organizations in his accustomed environment; and these must be replaced with new dependency relationships involving the staff and structure of the hospital. The factor of greater malleability means that the child is apt to make this adaptation rather readily, and without much resistance. Unfortunately, however, the same process may not occur as easily in reverse, when the child leaves the hospital. The transition from institutional life back to normal community living is likely to be much more difficult. The child's family may have "closed ranks" after his departure, forming what amounts essentially to a new group, of which he is no longer considered a part. It may be very difficult to return to the atmosphere and demands of the public school setting after an absence of a year or two. Most important of all, the child may have difficulty seeing himself as "well" and "normal" after having been allowed, or even encouraged, to think of himself as "sick" and "abnormal."

The effort to avoid or combat the process of institutionalization in the program described herein rests upon these working principles of primary significance: (1) Providing treatment as near the home as possible. The trauma of separation and of readjustment both at admission and at discharge is kept to a minimum. Treatment is extended at a time and place convenient to the patient's family. Persons and resources normally supportive to the child are accessible for the use of both child and therapist. (2) Continuation of living experiences in the normal community. Though living away from home, each child continues to participate in ordinary activities of the normal community insofar as possible, including attendance at a public school and participation in the usual community recreational program. (3) Continuing close involvement of the family. Regular contact with the family is maintained, and when indicated, parents and siblings are offered appropriate treatment. (4) De-emphasis of the concept of "illness." Daily living experiences are kept as normal as possible; the child is not relieved of responsibility for his own behavior; and pressure to conform to the usual requirements of normal social living is exerted by the staff.

The Treatment Program - Admission to Discharge

All children are seen on a voluntary basis. Although courts may refer a child, the Community Services Team does not admit children under court commitment. Children may also be referred by doctors, ministers, welfare workers, school personnel, or by the child's parents. After a rather extensive pre-admission evaluation procedure, each new child selected for admission, as well as his parents or guardians, signs an application for voluntary admission. Once admitted, each child promptly starts to school and is expected to follow the normal program experienced by the other children.

The children live in ordinary cottages formerly occupied by staff members, instead of in institution-type ward buildings.* The cottages are located in a semi-isolated location at one end of the hospital grounds, separated from the nearest adult wards. The whole area is not particularly different from a residential street in town. In their daily cottage living, the children are supervised by undergraduate college students, instead of by the usual psychiatric technicians. This again helps to avoid the usual institutional atmosphere, since these students are more identified with the local community than they are with the hospital. They are gone during parts of the day, attending their classes, just as normal parents are also out of the home during part or all of the day; on the other hand, they are present in the morning up until the time that the children go to school, and are present again in the late afternoon and evening, and through the night. Thus, there is continuity of care, just as is provided to the normal child by his parents, and in contrast to the usual institutional arrangement where care is provided by psychiatric technicians working in shifts which change every eight hours.

Life in each cottage approximates normal family living. Four children live in each cottage along with two counselors. Meals are eaten in the cottages instead of in a cafeteria. The children are expected to keep their rooms clean and neat, and have other assigned chores as well. The usual privacy of the home is respected; even Community Services Team members do not enter a cottage without first knocking on the door and obtaining permission to enter. Birthdays

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*The description which follows refers to the program originally developed at Colorado State Hospital. The extension of this program into local communities is described at a later point in the paper.

and other special days which mean a lot to children, such as Halloween, are observed in traditional fashion, as they would be at home.

Every effort is made to keep the child from seeing himself as "sick", helpless or unable to take responsibility. Tranquilizing medications are used sparingly. (One year the total drug purchases for sixteen children amounted to less than the veterinary bill for the dog which served as mascot for the children.) The cottage counselors urge the children to take age-appropriate responsibility for themselves, and to perform up to the limits of their ability. The counselors set a good example for the children to follow, by performing at a high level in the matter of obtaining an education, a most important consideration for children; and by their generally responsible and appropriate behavior and attitudes.

The School Program

Every child attends a public school in town, mingling with normal children from the community, and living up to the usual expectations and demands of the public school setting, the same as any other child. An unbroken relationship and identification with normal educational values is thus maintained, which is of the utmost importance for every child; and again, the child is discouraged from seeing himself as "sick" or "different" compared with other children. The team's professional staff is always immediately available as a source of support to the personnel of the several schools in which the children are placed. The children are also given a full measure of support and encouragement in connection with any extra-curricular activities in which they show an interest. Consultation is provided to teachers and principals by the team psychiatrist, social worker, and nurse. One staff member takes the primary role in relating to each school, to aid in communication. These staff members belong to the Parent Teachers

Association and attend school functions whenever possible. School nurses frequently contact the team nurse in health matters. There is also often direct communication between teachers and cottage counselors, regarding the children's homework and school activities. Most teachers have visited the program for a first-hand view of the children's environment.

Most of the children have serious reading difficulties, and average about two grade years of deficiency in this area. A special six weeks Remedial Reading Project was, therefore, developed as an integral part of the summer treatment program. This project has been conducted for the past five summers by a different reading specialist each year. The teacher initially evaluates each child to identify his specific reading problem. Children are then seen individually, or together with one or two others, for intensive instruction. At the end of the six weeks, each child is then re-evaluated to measure progress. This program has proven extremely successful. The average improvement in reading ability has been one and one-half or two grade levels. Periodic retesting or reading ability, performed either in the Community Services Program or in school, has consistently demonstrated the permanence of these improvements.

Special Treatments

Although the children are encouraged not to think of themselves as "sick", the Community Services Program does provide intensive treatment. Each child is seen at least once weekly in individual psychotherapy. Some children are seen more frequently. All children are also seen at least once weekly in activity group therapy. Perhaps the program's most important treatment modality is the milieu therapy, which is mediated primarily by the cottage counselors under close supervision. These carefully selected young people provide excellent identification models for the children, but avoid the role of parent substitute.

Perhaps their relationship to the children might be thought of as like that of an aunt or uncle. As college students, they have an obvious personal interest in education with which the children can identify. Similarly, as individuals with generally high moral standards and high levels of motivation, they encourage the children, by example, to live up to the best that is in them.

In addition to individual, group, and milieu therapies, the child will ordinarily be seen almost as frequently in family therapy. The staff employs a wide range of family therapy efforts, many innovative in form, in a determined effort to involve the entire family in meaningful treatment. It is a team policy that some contact is to be made at least twice a month with the family of every child in residence. Such contacts may take the form of visits to the hospital by members of the family, or visits to the family home by staff members. Both are involved in some cases. Some of the staff make themselves available regularly on evenings and weekends to meet with visiting families. Contacts with the families cover everything from exchanging information about the child to individual psychotherapy, marriage counseling or family therapy. These frequent contacts are also intended to emphasize the fact that the family has not relinquished its responsibility for the child, in spite of the child's temporary removal from the home; and this is further reinforced by asking the family to provide spending money and some clothing items to the child. Finally, the child is sent on frequent home visits unless this is contra-indicated from a treatment standpoint. Where home visits are indicated, they usually are considered therapeutic.

Staff Education as Treatment

It is often difficult to distinguish between in-service training and treatment, and this is especially true in the Community Services Program, where

supervision of therapy is a mandatory policy, and where demonstration of normal interaction is made feasible by the small number of staff and children involved.

In-service training is an ongoing daily function carried out by both formal and informal methods. Each cottage counselor receives a scheduled hour of individual supervision weekly, with the focus on understanding feelings and interpersonal relationships. Each cottage has a scheduled weekly conference, which is attended by the professional staff and the two counselors. In this meeting, each child is discussed individually and the therapeutic efforts with the child and his family are reviewed. There is considerable emphasis on the psychodynamics of each child, situation, or problem discussed. A weekly meeting of all cottage counselors and staff is also held, to discuss general issues related to the overall program, to communicate appropriate information, and to utilize the group approach to problem solving. In addition, many informal "supervisory" sessions are held with counselors, to handle various crises or emergency situations. Another educational method frequently utilized is direct demonstration. This occurs whenever any staff member finds himself in a situation with the child which merits direct intervention. Such on-the-spot involvement is both realistic and meaningful, as well as educational for the observing counselors.

An important part of the in-service training is conducted at Southern Colorado State College, in cooperation with the Department of Psychology. The entire professional staff is responsible for teaching a course entitled "Seminar in Child Development," which was primarily designed for those who are present or prospective counselors, but is open to other students. This class offers specific training in the art of child care, and understanding of fundamental child development and psychopathology concepts.

Finally, the use of consultants has been an important part of the educational process in the Community Services Program. The consultants may be psychiatrists, psychologists, or social workers. Both supervision and in-service training may be built into the consultative services from time to time. Since the consultant is from another staff or program, whatever he says or does seems to have a charged meaning, and his relationship to the regular staff is somewhat special.

The Community Psychiatry Program

The Community Services Program derived its present name from an increasing concern with the large segments of population which for a variety of reasons do not utilize present mental health resources. The name also comes from specific efforts designed to bring meaningful mental health services to these segments of population in program and treatment forms which will be utilized. Participation in a program (the Child Research Unit) which worked in partnership with local schools, the local college, and local recreational resources created in the staff an awareness of the socio-cultural factors which create ignorance, suspicion, hostility, and apathy in certain groups toward agency and institutional resources, and consequent under-utilization by those groups.

In Pueblo, much of this under-utilization occurs in groups having members in great need of counseling and treatment. These groups include the Spanish-American, the Negro, and certain Caucasian persons in blighted areas of the community. In general, these groups are characterized by a greater lack of education; a more serious rate of unemployment; a higher incidence of drug abuse, alcoholism, and delinquency; and more severe general health problems. These groups also reflect, often because of racial, lingual, or cultural factors, more of society's broken promises, greater alienation, and a serious

lack of public concern. In other areas of the state, these same problems were encountered, and were even more difficult because distance, mountainous terrain, and serious lacks in local mental health resources and efforts added barriers to obtaining needed services. The need for new approaches was obvious if effective mental health services were to be provided in these isolated communities.

In order to understand the new approaches developed by the Community Services Program, it may be helpful to view that program as part of the overall hospital program. Colorado State Hospital serves the entire state, with the exception of the eight county Denver Metropolitan Area which is served by Fort Logan Mental Health Center. In 1962, Colorado State Hospital was re-organized into a number of semi-autonomous geographical divisions, each of which was given the responsibility for treatment of patients from one specific geographical region of the state. There are at present four such divisions. In addition, five specialized treatment units were formed to treat patients with special problems, viz., the Alcoholic Treatment Center, the Geriatrics Division, the Security Treatment Center, the General Hospital Services, and the Children's Treatment Center.

The purpose of decentralization was to re-organize the Hospital into treatment units of manageable size, which would also be more responsive to particular regional needs. Each clinical division was provided with its own physical facilities, staff, and operational budget.

The geographical orientation of the basic treatment divisions made possible the development of relationships with the community served throughout the State, in a way that had not been possible or even envisioned when the hospital was a single entity, serving a total area of 104,000 square

miles comprising 63 counties. The treatment teams of the geographical divisions travel extensively throughout the counties they serve, conferring with local welfare workers, public health nurses, probation officers, sheriffs, judges, ministers, public officials, physicians and others, concerning problems presented by ex-patients or problems unique to the communities, and participating in pre-admission evaluations.

The staff of the Community Services Program proposed in 1968 that gradually, cottage by cottage, the facilities and functions of that program be transferred from the grounds of Colorado State Hospital to a number of local communities having special needs. The overall program approach in each community would be similar to the original Child Research Unit program, as described above, but would be modified in accordance with the special needs of each community. The communities selected for initial exploration were all in the region served by Colorado State Hospital's Southern Division, and a partnership was established with that treatment unit. The Southern Division team was to provide adult services and the bulk of the community organization effort, while the Community Services team would establish local residential treatment centers and specific treatment modalities for child and family mental health problems. The local residential center would serve as the operational base for both treatment units, and a variety of community mental health services would also be provided by other specialty divisions of the Hospital, especially the Alcoholic Treatment Center. From the beginning it was stated that the purpose of this program would be to augment and complement existing community mental health efforts, rather than to compete with them in any way. The first three communities selected for exploration were the six-county San Luis Valley region, the city of Trinidad, and within the community setting of Pueblo instead of the hospital grounds.

The San Luis Valley Community Services Program

Community exploration and organizational efforts preceded the establishment of the first such community program in the San Luis Valley. The Valley is a six county region isolated by rugged mountains, and located approximately 100 to 180 miles from the State Hospital in Pueblo. It is accessible to Pueblo only by one highway, which can be treacherous six months each year because of the high, often snow-covered La Veta Pass which the highway crosses. Most travel to the Valley by State Hospital staff is by airplane. Obviously, most Valley residents needing State Hospital services are seriously handicapped in obtaining these services due to distance and travel difficulties.

The San Luis Valley is an agricultural area, and its economy fluctuates with the weather, the seasons, productivity, and prices of the agricultural products. A large percentage of the population are Spanish-American crop-hands, whose earnings are dependent on the fluctuating agricultural economy. There is a recognized poverty situation in the Valley with a high incidence of alcoholism and a variety of related problems.

Through public meetings, residents and agency representatives were acquainted with the proposed program, and the response via letters and phone calls indicated that they were aware of unmet mental health needs in their area and were willing to help in establishing a local residential facility.

The Community Services Team began phasing out one of the children's cottages at the State Hospital in preparation for opening a similar cottage in the town of Alamosa, which was selected both because it is centrally located in the Valley, and because it is the home of Adams State College. The major problem was finding a suitable cottage, not an easy matter in a small college town with limited employment opportunities. The cottage finally selected was a

four bedroom house, recently vacated and structurally sound, but not suitable for simultaneous residential treatment of both boys and girls. It was therefore decided to accept only boys for residential treatment in the cottage, and to offer similar treatment for girls in the cottage at the State Hospital. The Alamosa cottage provides sleeping areas for four patients and two resident counselors, rooms for therapy sessions, office space, a kitchen, a room for arts and crafts, and playground space.

Besides serving as a residential treatment center for the Community Services Team, the cottage acts as a hub for mental health services provided by Southern Division, the Alcoholic Treatment Center and the Children's Treatment Center. This concentration of services in one geographic area could be the beginning of a comprehensive mental health center for the San Luis Valley, a program goal.

Just as the original program (the Child Research Unit) served as a pilot project for establishing the feasibility of a new type of residential treatment for disturbed children, the San Luis Valley program is seen as a pilot project in developing a new type of partnership between State Hospital and community. Local resources are utilized wherever possible. Most foods are bought locally. The local general hospital and community physicians, dentists, and nurses provide practically all medical care needed by patients. Community recreational resources are used. In-service training efforts are extended to qualified community agency, school, and college staff, and a number of these persons will work as volunteer clinical staff in an effort to update their clinical skills. An attempt is made to maintain communication with other community agencies. A community committee serves as an advisory board for the program. The Alamosa School System will provide a program for

each child admitted, and in turn the school system is offered increased consultation.

The local staff for the San Luis Valley program consists of an experienced male residential supervisor; two male college students employed as cottage counselors; and a housemother-cook who cleans, cooks, and provides mothering for the patients. Staff coverage is extended by travel teams of psychiatrists, psychologists, social workers, nurses, educators and other personnel who visit the Valley twice a week to provide a wide range of clinical services. These services are augmented by local professional persons, who work under staff supervision as volunteer clinicians.

Establishing the residential cottage in the San Luis Valley is a natural extension of the Community Services Program and should enhance its treatment efforts. It should make less difficult for Valley patients the transition from normal community living to institution and back to the normal community. Total treatment time should be shortened. Families can manage necessary travel for participation in therapy, and hopefully will feel less threatened than they might in the much larger and more complex State Hospital setting. The local setting, the lack of size and complexity, the informality afforded in the community setting, all should contribute to better community understanding and public acceptance of available mental health services. These expectations will need to be demonstrated, of course, since the program is still too new to determine its overall effects.

Planned Community Centers

A number of communities have expressed interest in developing community programs similar to that in the San Luis Valley. Serious exploration and planning has been conducted in both Trinidad and Pueblo, and it is probable that programs will be developed in these two communities in 1969. Although

both programs would be similar to the programs described, they would also offer different features to meet unique community needs and situations. For Trinidad a slightly larger, co-residential center is planned as part of that community's Model Cities Program for expanded and improved local services. For Pueblo the co-residential program may be part of a larger walk-in clinic offering a wide range of services to a multi-problem area of the city. Program exploration in other regions and communities will continue, and in each location program planning will be based on local situations and needs.

Discussion and Implications of the Program

As with all programs which are successful, the Community Services Program has been and is successful for a wide variety of reasons. Any program must fulfill in a timely way a definite local need in an acceptable manner which augments and allies itself with existing local resources. In all these ways the Community Services Program has been most fortunate. It was developed as the first children's program in the State Hospital when that hospital was developing a decentralized program and struggling to become an adequate, dynamic treatment force. Being a highly specialized program, it was only mildly competitive with existing hospital and community resources. Through cooperative and consultative efforts the program allied itself with a wide range of community programs. The program was successful also because of the efforts of its staff, who had a dream and who persisted in the face of many frustrations in charting new courses.

With local modifications this program may have meaning for others. Probably there is no disagreement as to the pressing need for residential treatment services for emotionally disturbed children in Colorado and throughout the nation. The problem is how to provide such services. One of the worthwhile

things about the program is that it might be studied as a possible model for similar programs that could be established without too much difficulty in various communities. If it is feasible to place the basic responsibility for management of the children and for milieu therapy in the hands of undergraduate college students, then any town in which there is a college could conceivably have this type of treatment center. Consulting professional staff would also need to be available, but probably only on a part-time basis; such staff might be obtainable from a nearby community mental health center, from the college faculty, and from other sources. The project would require one or two full-time administrative staff people, one or two houses with a sufficient number of bedrooms, and satisfactory cooperation from the local school officials as well as general support from community leaders. None of these requirements seem to represent insurmountable problems. Whether such a relatively simplified treatment center in a local community will be effective or not will have to be determined by actually trying it out; however, this program does seem to represent a noteworthy step in this direction, and no major contra-indications have developed.

For others who would follow this model it would help to start with a community and school system that recognizes the need for such a program and either initiates its development or is directly in on the planning from the beginning. This should insure greater cooperative participation and eliminate much of the community resistance. The community programs should be geared to the unique circumstances of each community incorporating the strengths and resources already present, and designed to attack the most significant and pressing problems of that community. Of utmost importance is that existing programs be complemented and implemented and that the program not

enter into competition with existing programs or agencies.

Considerable emphasis should be placed on the meaningful involvement of parents in the treatment program. This was found to be absolutely vital for a child's improvement and eventual success. The same kind of involvement can also be accomplished with guardians or foster parents. At times the staff required a pre-admission written contract with a particular child welfare department in order to insure such cooperation.

The maintenance of a high level of expectation must be continually stressed, especially in regards to the college students and children. Whenever the staff became lax in this area, the entire system of operation was adversely effected. In many aspects the characteristics that the college students display can be looked at from the point of view of peace corps psychology in that one is expected to do the impossible and it works.

SUMMARY

After five years of experience the program has developed a dynamic treatment model utilizing college students as child care workers, and using community schools and resources in order to maintain an optimistic viewpoint for the patient and to avoid institutionalization. Treatment is offered to the patient's entire family. The program has been extended to one isolated six-county community, and other community programs are currently being planned. Suggestions are made for modifying this approach to other areas.

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